

Critical Ingredients of Intensive Case Management:
Judgments of Researchers/Administrators, Program
Managers and Case Managers

by
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Richard W. Schaedle

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Abstract

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Richard W. Schaedle

Chairperson: Professor Irwin Epstein
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Advisor: Professor Joann Ivry

Intensive Case Management (ICM) did not evolve from a single, well-defined model format but from different case management models. As a result, it has been vaguely defined as meaning more "intense" than usual case management, thus highlighting the lack of consensus about ICM's definition and parameters. Despite these differences, ICM programs aspire to a set of common principles and core operational functions derived from the concept of continuity of care. Recent literature reviews have found mixed results regarding studies examining ICM effectiveness (e.g., psychiatric hospitalizations, etc.). It has been difficult to make comparisons between studies because operational definitions have not been standardized.

This study attempted to construct a program theory that unifies the various ICM practice orientations and specifies its operationalization so that more effective implementation

and evaluation can occur. An integrative approach was used that synthesized information from the existing literature and by surveying three distinct stakeholder groups (researchers/ administrators, program managers, case managers) for their perspectives.

Twenty-two researchers/ administrators who were considered experts, 21 ICM program managers and 46 ICMS working in 4 separate programs in New York City rated the importance of 68 program elements. Respondents identified 32 out of 68 program components as critical. A preliminary fidelity index was developed from these results. In addition, empirically derived norms for 12 model specifications were operationalized (e.g. ideal caseload size, etc.). Agreement among all respondents on ratings of importance was high (intraclass $r = .92$), although there was less agreement for some areas and respondent groups. Consensus was highest among ICMS, followed by program managers and experts.

Significant findings included the perceived importance of a bachelors degree in human services, access to psychiatric consultation, optimum caseload size of 1:11, access to funds for client purchases and 85% of contacts occur in the community. Under treatment foci, a number of practice elements from the Personal Strengths and Rehabilitation perspectives were identified as critical.

Additional suggestions from respondents focused on ICMs participating in the hospitalization/discharge process, how revenues are derived, and the lower success rates ICM has with clients suffering from character disorders and severe substance abuse. Results reinforced the idea that ICM is a "client driven" intervention in contrast to typical case management programs that are "system driven".

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While I doubt very many people will ever read this document, I hope that the information contained in it does influence how Intensive Case Management programs are constructed and operated. This document is for the benefit

of people suffering from a terrible illness, whose pain and suffering many of us will never know since we have never walked in their shoes.

Finally, I would like to dedicate this dissertation to my father, Gregor Schaedle. Without his hard work, dedication, and role modeling, I would never have been able to achieve what I have accomplished today.

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Chapter I

Introduction

This study seeks to advance social work practice by focusing on the development and evaluation of a community based intervention aimed at the seriously mentally ill. Intensive Case Management (ICM) is one form of community support developed during the era of deinstitutionalization. This program model aspires to a set of common principles, regardless of the underlying practice philosophy chosen by administrators. The model includes a set of core functions such as outreach, assessment, service planning, linkage, monitoring, and client advocacy. It also contains certain operational features such as low client staff ratios; in vivo treatment; frequent and intense contact; and open-ended lengths of service. These principles are derived from the concept of continuity of care that defines the boundaries of intensive case management and unifies its various practice approaches.

Many studies have been undertaken asking whether ICM works as a community support intervention. Recent literature reviews have found mixed results in terms of outcomes regarding psychiatric hospitalizations, total costs of care, client symptoms and treatment compliance. The evaluations undertaken to date have focused primarily on the

relationship between program inputs and outputs with little regard for the transforming processes or throughputs that occur in the middle (Chen, 1990). In addition, research has been negatively affected by the lack of basic program description and documentation regarding implementation. Because operational definitions have not been standardized, it is difficult to make comparisons between studies. We do not know if failure implies that the theory on which ICM is based is incorrect or whether the failure is related to problems of implementation.

The question arises about what core set of program ingredients define ICM as unique and whether a consensus exists about these elements. To answer these questions, an attempt must be made to identify the critical ingredients of ICM so that "program fidelity" can be documented and implementation standardized. Fidelity allows us to determine whether programs that espouse the same philosophy or approach are actually adhering to the same principles that make the program model unique.

Program theory highlights the importance of identifying the critical elements of intensive case management. Program theory is the "construction of a plausible and sensible model of how a program is supposed to work" (Bickman, 1987). Chen (1990) describes program theory "as a specification of what must be done to achieve desired goals, what other important impacts may also be anticipated, and how these

goals and impacts are to be generated." A good program theory will describe the elements and components of a program.

Often, program outcome failures are either due to the wrong theory or to poor program implementation (Suchman, 1967, Weiss, 1972). Program theory failure cannot be distinguished from program implementation failure unless there is evidence that the program was implemented with fidelity (Bickman, 1987). As a result, evaluators often find themselves in the position of developing the program theory to create valid measurement and design plans. Only when programs are implemented with integrity can evaluations then be considered a test of the program's theory.

The aim of this study will be to identify the critical elements for ICM based on the core functions and operational features identified in the literature and by surveying stakeholders who are currently working in ICM. By making explicit what these core elements are and by developing operational definitions for them, the author hopes to increase the substantive knowledge regarding the ICM model so more effective implementation and evaluation research may occur.

Chapter II

Historical Context

Policy regarding the "treatment" of persons with chronic mental illness evolved in a historical context that has taken several directions since the 18th century. Before the mid 1800s, destitute individuals suffering from chronic mental illness fell under the system of poor laws and received no differential treatment or entitlements. They were either placed in a local almshouse with the rest of the indigent population or in private dwellings at the town's expense (Rocheftort, 1993). The care provided in county institutions and on rural farms was inadequate and a number of problems existed with these arrangements. Persons with mental illness were often preyed upon by other residents or staff in poorhouses and living conditions were reported to be ghastly. Some were exploited for their labor by local farmers or by businesspeople with political connections (Trattnor, 1994).

During the early 1800s, a large segment of the medical community began to subscribe to the phrenological theory as an explanation for insanity. The theory held that insanity was due to physical lesions of the brain and thus could be considered as physical in nature. In addition, insanity also had an important psychological element that could be caused

by emotional and environmental factors. These ideas promoted the belief that the mentally ill suffered from a condition requiring a separate treatment facility designed to provide humane care.

By the mid 19th century, a reform movement led by Dorothy Dix focused on promoting a policy that would segregate persons with mental illness from other residents within poorhouses. Awareness about the number of insane persons and the new theories regarding its etiology led to the founding of a new wave of mental hospitals. In 1865, the New York State Legislature was the first to authorize funds for the opening of the Willard Asylum for the Insane. By 1890, the State of New York passed the State Care Act under which the State assumed complete responsibility for the care and expense of all the insane poor (Katz, 1986). Over the next sixty years, State asylums were expanded to house and treat over 90,000 individuals in New York State.

At the time, the idea of creating State institutions to care for the mentally ill was considered a radical approach. While most progressives favored segregating individuals with mental illness from county poorhouses, there were nevertheless major disputes between county superintendents and State officials about whether asylums would improve conditions for the mentally ill. Initially, asylums were small and reputed to be responsive to patients in their care. By the 1890s, however, demand for beds had so

outstripped supply that large facilities were being constructed with up to 2,000 beds. County superintendents complained that asylums were costly, dehumanizing and located too far from patients' families. They advocated for the advantages of small county institutions that provided warmth, accountability and access to family and friends. In contrast, State policy makers distrusted local institutions reputed to be poorly managed. They were committed to the views of "experts" on mental illness who advocated removing the mentally ill from poorhouses so that they could receive "treatment". State officials were also intrigued by the advantages of centralization and economies of scale that large asylums could provide (Rothman, 1980). Ultimately, the controversy about whether responsibility for care should remain with the local county or State had less to do with the issue of quality care than with the expansion of State power over local government.

During the 1920s, public opinion regarding State Hospitals began to change. Asylums had become overcrowded, the buildings began to deteriorate and treatment and quality care were rarely provided. The institutions became impersonal, restrictive and dehumanizing settings where the main focus was on warehousing many of the mentally ill. Hospitals for the insane now resorted to using drugs, surgery and mechanical restraints (Rocheffort, 1993). Four new therapies originating in the 1930s attracted special

interest and fueled the progressive anti-institutional movement rooted in religious humanitarianism and secular reform. These were insulin-coma therapy, metrazol-shock treatment, electroshock therapy and lobotomy, all of which were administered to tens of thousands of patients during the 1930s, 1940s and 1950s (Rochefort, 1993). Scandalous exposes of conditions and treatments at state institutions were becoming more frequent and difficult to ignore.

-

During the 1950's and early 1960's three concurrent developments led to profound changes in State policies regarding persons with mental illness. First, breakthroughs in psychopharmacology for mental illness resulted in the manufacture of new classes of medication shown to be effective in controlling the positive symptoms of severe mental illness. This innovation led to the belief that persons with severe mental illness could function in the community.

While new advances in psychopharmacology occurred, the community mental health movement began to gain strength and advocate for change (Stroul, 1986). This movement championed the idea that persons with severe mental illness should be reintegrated into their communities along with new treatment approaches that would avoid isolating patients for extended periods. This concept formed the basis of the Community Mental Health Centers Act passed by Congress in 1963.

Community mental health centers were to be created throughout the nation to facilitate the treatment of mental illness in the least restrictive setting possible.

Finally, during the 1960s Congress created numerous federal welfare entitlements (Medicare, Medicaid, Supplemental Security Income, Social Security Disability Insurance) which were to provide medical insurance for the poor, and fund outpatient treatment for people with mental illness. These entitlement programs would provide the funding mechanisms that would enable patients to be discharged from hospitals into the community (Mechanic, 1987).

New drugs coupled with the community mental health movement and the creation of Medicaid unleashed a new State policy called "deinstitutionalization" of the mentally disabled. The fiscal incentives to State government for deinstitutionalization were powerful. State hospitals were expensive to maintain and a significant drain on State tax revenues. Deinstitutionalization would allow patients to reintegrate themselves into the community so that they could receive treatment in the least restrictive setting. At the same time Medicaid and SSI would pay for the services necessary to maintain patients in the community while relieving States of the fiscal burden of maintaining State Hospitals. The number of patients in State mental hospitals throughout the United States declined from 559,000 in 1955

to less than 150,000 in the early 1980s (US Dept. of Health and Human Services, 1980). In New York State alone the number of patients in State institutions declined from 95,000 in 1955 to 6,000 in 1997 (N.Y.Times, October 4, 1997).

As the policy of deinstitutionalization was carried out during the 1970's, attention began to shift from the deplorable conditions at large mental hospitals to the problems arising from the lack of community support systems for the mentally ill (Stroul, 1986). Without community support programs in place to treat and support individuals with mental illness, patients released from institutions found themselves in poorly run nursing homes, boarding houses, municipal shelters and on the street (Harrington, 1985). Localities were not equipped to respond to this new problem because they lacked the necessary planning expertise and financial resources. The inability to meet discharged patients' basic human needs for shelter, food, clothing, income and medical care led to a substantial increase in the number of homeless mentally ill during the 1970's. Newspaper articles and films with titles such as "Deinstitutionalization: Out of Their Beds and Into the Streets" and "Back Wards to Back Alleys" highlighted the human tragedy of patients released from institutions (Santiestevan, 1975; Trotter & Kuttner, 1974).

Significant Federal financial support for outpatient

treatment services and preventive mental health programs necessary to address the problems of the mentally ill never materialized. According to a Ralph Nader study group, community mental health centers (CMHC) were never held accountable for the objectives that they were originally created for. CMHCs often treated patients who were higher functioning and able to participate in traditional psychotherapy (Trattner, 1994). In retrospect, however, CMHCs were generally not organized to assume responsibility for the severely mentally ill and were never designed to provide all the needed support services required by this population (Stroul, 1986). In addition, State involvement in the development of the CMHC system was low, and largely uncoordinated with the deinstitutionalization process (Shern et al., 1989). What was needed was a full range of treatment and support services designed to maintain chronic patients in the community.

-

Many experts agreed that the lack of supportive and rehabilitative programs in the community were responsible for the problems of deinstitutionalization. Adequate care for persons with chronic mental illness needed to include supportive housing, socialization, social rehabilitation, vocational rehabilitation, employment opportunities, educational services, income maintenance, social services, medical and nursing care, transportation and homemaking

services (Talbott, 1978).

The National Institute of Mental Health began to address the problems of deinstitutionalization and community based care in 1974 with the formation of an internal task force focused on long term solutions. As a result of its work, the Community Support Services (CSS) initiative was launched in 1977 to assist States and local communities in developing the array of supports and services required by the severely mentally ill (SMI). NIMH defined the concept of CSS as "an organized network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (US Dept. of Health and Human Services, December 1980). The population targeted were "adults eighteen and over, with severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements or employment, but for whom long term twenty-four hour care in a hospital, nursing home or protective facility is unnecessary or inappropriate" (NIMH, 1980).

The CSS strategy drew its ideas from the medical model, rehabilitation model and social support model in an attempt to address the biopsychosocial needs of individuals with long-term mental illness. The strategy emphasizes ten

essential components crucial to providing adequate opportunities and services for persons with long-term mental illness (US Dept. of Health and Human Services, September 1980).

- o **Location of Clients/Outreach-** Locate clients, reach out to inform them of available services and assure their access to needed services and community resources by arranging for transportation, if necessary, or by taking the services to the clients.

- o **Assistance in Meeting Basic Human Needs-** Help clients meet basic human needs for food, clothing, shelter, personal safety, general medical and dental care, and assist them to apply for income, medical, housing and other benefits which they may need and to which they are entitled.

- o **Mental Health Care-** Provide adequate mental health care including diagnostic evaluation; prescription, periodic review and regulation of psychotropic drugs as needed; and community-based psychiatric, psychological and/or counseling and treatment services.

- o **24-Hour Crisis Assistance-** Provide 24-hour, quick response crisis assistance directed toward enabling both the client and involved family and friends to cope

with emergencies while maintaining the client's status as a functioning community member to the greatest possible extent. This should include round-the-clock telephone services, on call trained personnel and options for either short-term or partial hospitalization or temporary community housing arrangements for crisis stabilization.

- o **Psychosocial and Vocational Services-** Provide comprehensive psychosocial services which include a continuum of high to low expectation services and environments designed to improve or maintain client's abilities to function in normal social roles. Some of these services should be available on a indefinite duration and should include, but need not be limited to, services that train clients in daily and community living skills; help clients develop social skills, interests and leisure time activities; and help clients find and make use of appropriate employment opportunities and vocational services.

- o **Rehabilitative and Supportive Housing-** Provide a range of rehabilitative and supportive housing options for persons not in crisis who need a special living arrangement. The choices should be broad enough to allow each client an opportunity to live in an